Medicare Financial Management Manual

Chapter 10 - Provider Statistical & Reimbursement Report

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10 - Provider Statistical and Reimbursement System - (Rev. 10, 08-30-02)

A2-2241

CMS provides each intermediary a standard Provider Statistical and Reimbursement System (PS&R) to interface with billing form CMS-1450. This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. Providers also must use the reports in preparing cost reports, and must be able to explain any variances between the PS&R report and the cost report.

Systems user reference manuals and software are distributed centrally. Updates to the program are prepared and released as needed. Implement and operate the system in accordance with the following guidelines. The intermediary shall establish procedures to integrate provider FY data collected prior to PS&R implementation.

20 - Intermediary Use of PS&R System Reports In Cost Settlement Process - (Rev. 10, 08-30-02)

A2-2242

20.1 - Provider Summary Report - (Rev. 10, 08-30-02)

A2-2242A

The intermediary shall use information about charges, Medicare patient days, coinsurance days, etc., from the provider summary report in the cost settlement process unless the provider furnishes proof that inaccuracies exist. It shall obtain the provider summary report used in the settlement of the cost report at a date as close

as possible, but no earlier than 90 days, prior to the settlement date. The Provider Reimbursement Manual directs providers to use the provider summary report in preparing the cost report. Therefore, the intermediary shall furnish each provider with a year-to-date provider summary report within 60 days of the end of the provider's FY, and provide updates. (See §30.2 for a description of the report.) The report may be furnished at more frequent intervals upon mutual agreement by the intermediary and the provider. The intermediary shall furnish the report on electronic media or paper. It shall use electronic media when cost effective. The provider is expected to make reasonable efforts to process electronic media.

20.2 - Payment Reconciliation Report - (Rev. 10, 08-30-02)

A2-2242B

The payment reconciliation report provides detailed data that supports the provider summary report. The intermediary shall use this report to resolve discrepancies between the provider's data and the summary report.

30 - Description of Reports Available from Standard PS&R System - (Rev. 10, 08-30-02)

A2-2243

Two reports are produced from the PS&R system. The first consist of statistical reports showing claim activity. These can be used for accounting and audit purposes regarding provider remittance. They are the main output and purpose of the PS&R system. The second show the results of processing and are used for operations control and monitoring of the flow of data through the PS&R system. They include error reports, table listings, and results of updates and systems messages from data center staff. They also provide a detailed audit trail of the data. They are explained in the table maintenace and file maintenance sections of the PS&R User Reference manual.

All reports produced from the PS&R system list a program ID and run date. The program ID is a unique number that identifies the program that produced the report. The run date shows the specific date that the report was produced. These fields are for informational purposes only in the event of possible problems.

Statistical reports produced are:

1. Payment Reconciliation Report
2. Provider Summary Report
3. DRG Summary Report

30.1 - Payment Reconciliation Report - (Rev. 10, 08-30-02)

A2-2243A

This report shows in detail claims accepted by the PS&R system with totals by provider within report type. All claims processed by the PS&R system will be written

to this report on a monthly basis. It serves as an audit trail for monthly activities and for comparison to the summary report.

FREQUENCY: Upon request.

FIELD DESCRIPTIONS:

1.	Service Month End	The last day of the month for services included.
2.	Run Date	The date on which the system produced this report.
3.	Provider FYE	The month and day that mark the close of the provider's FY.
4.	Provider	The number identifying the provider is followed by the provider's name as it appears on the provider table.

NOTE: The name "unknown provider" indicates that the provider number was not found on the provider table at the time the report was produced. It is possible that the YTD summary file contains some records for this provider number. The provider table should be updated before further processing. Only the affected reports need rerunning.

5.	Report Type	Identifies the type of report, using a 3-digit number.
6.	Paid Dates	The beginning and ending dates of the period covered by the report.
7.	Patient Name	The first six letters of the patient's surname with the patient's first initial, as confirmed through data exchange with CMS.
8.	Patient Control Number	Patient control number from the PS&R UNIBILL file, as submitted by the provider on the UB-82 claim (CMS-1450).
9.	HICN	HICN confirmed through data exchange with CMS.
10.	Covered Days, Full	The number of inpatient days covered in full by Medicare.
11.	Covered Days, CO	The number of inpatient coinsurance days for which the beneficiary is liable under Medicare.
12.	Covered Days, Life	Number of lifetime reserve days used.
13.	Total Covered Charges	The sum of Medicare covered charges for all revenue code centers entered on the claim (CMS-1450).
14.	Gross Reimbursement	The sum of net reimbursement from Medicare plus the blood and cash deductible amounts, the coinsurance amount, and any interest paid.

15.	Net Reimbursement	The total amount the provider received from Medicare during the period indicated in the report.
16.	Cash Deductible	The inpatient hospital deductible payable by the patient.
17.	Blood Deductible	The cash blood deductible payable by the patient.
18.	Coinsurance	The patient coinsurance amount payable by the patient.
19.	Net Primary Payments Made Under MSP	The net amount payable by a higher priority health insurer that was used to reduce Medicare liability. This amount does not include full payments by other payers.
20.	DRG Code	For prospective payment providers, the DRG code which was assigned to this claim (CMS-1450). This information does not appear for other providers.
21.	From Date	The beginning date of service covered by the claim (CMS-1450).
22.	Thru Date	The ending date of service covered by the claim (CMS-1450).
23.	Paid Date	The date the remittance amount was paid to the provider.
24.	Bill Frequency	The bill frequency associated with the claim from the CMS-1450. The possible values for frequency are: 0 - Nonpayment/zero claim 1 - Admit through discharge claim 2 - Interim first claim 3 - Interim continuing claim 4 - Interim last claim 5 - Late charge only claim 6 - Adjustment of prior claim 7 - Replacement of prior claim 8 - Void/Cancel of prior claim

9 - Reserved for National Assignment

25. Discharge Status: Valid for inpatient claims. This indicates whether the patient was discharged. The list below shows how each discharge status is reported.

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged to another type of institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
08-09	Reserved for national assignment
10-19	Discharge to be defined at state level, if necessary
20	Expired (or did not recover - Religious Non Medical Health Care Facility Patient)
21-29	Expired to be defined at state level, if necessary
30	Still patient
31-39	Still patient to be defined at state level, if necessary
*40	Expired at home
*41	Expired in a medical facility; e.g., hospital, SNF, ICF, or freestanding hospice

*42	Expired - place unknown

*For use **only** on Medicare claims for hospice care.

26.	Revenue Codes	Each revenue code and its associated covered units and charges.
27.	HCPCS Codes	Each revenue code and HCPCS code with associated covered units and charges. HCPSC codes will appear on outpatient clinical lab, ASC, and Radiology reports.
28.	ASC Split Bill	Two or more bills have been created for PS&R processing, one containing ASC procedures only and one or more without ASC procedures.
29.	ASC STD OHD FEE:	ASC standard overhead fee, as calculated by the ASC Pricer program.
30.	RAD Split Bill:	Two or more bills have been created for PS&R processing, one containing Radiology procedures only and one or more without Radiology procedures.
31.	RAD Prevail Chg	Radiology prevailing charge or fee schedule amount as determined by one Radiology Pricer program.

30.2 - Provider Summary Reports - (Rev. 10, 08-30-02)

A2-2243B

Summarizes claim data and other information by revenue code required for cost report settlement and CMS reporting purposes. Time periods included on this report are specified by the user.

All outpatient ASC and clinical lab services reimbursed by HCPCS are summarized separately on the clinical lab report and the ASC report.

FREQUENCY: Upon request.

REPORT TYPES: A report is generated for each type. These report types are based on the first two digits of the Bill Type code on the provider's claim form (CMS-1450). Report claims which cannot be mapped to one of the report types under "UNKNOWN REPORT TYPE." PS&R system report types are:

110	Inpatient Part A
120	Inpatient Part B
130	Outpatient - All Other
131	Outpatient Renal

132	Outpatient - Part B 100 Percent
139	Outpatient - Radiology and Fee Schedule
140	Outpatient - Clinical Lab Nonpatient
210	SNF Inpatient Part A
220	SNF Inpatient Part B
230	SNF Outpatient
320	Home Health Part B with a Plan of Treatment
330	Home Health Part A with a Plan of Treatment
340	Home Health Part B without a Plan of Treatment
410	Religious Nonmedical Health Care Hospital - Inpatient Part A
420	Religious Nonmedical Health Care Hospital - Inpatient Part B
430	Religious Nonmedical Health Care Hospital - Outpatient - All Other
431	Religious Nonmedical Health Care hospital - Outpatient - Renal
432	Religious Nonmedical Health Care Hospital - Outpatient - Part B 100 Percent
440	Religious Nonmedical Health Care Hospital - Clinical Lab Non-Patient
510	Religious Nonmedical Health Care Ext Care - Inpatient - Part A
520	Religious Nonmedical Health Care Ext Care - Inpatient - Part B
530	Religious Nonmedical Health Care Ext Care - Outpatient - All Other
650	Intermediate Care - Level I
660	Intermediate Care - Level II
670	Intermediate Care - Level III
710	Clinic - Rural Health
720	Clinic - Free Standing Renal Dialysis
730	Clinic - Free Standing
740	Rehabilitation Facility and CORF
790	Clinic - Other
810	Hospice - Non-Hospital Based
820	Hospice - Hospital Based
830	Ambulatory Surgery Center
840	Free Standing Birth Center

890	Special Facility - Other
999	Unknown Report Type

NOTE: In all cases other than outpatient, the report type ties directly to the type of bill entered on the claim (CMS-1450). For outpatient bills, the distinction is broken out further to identify the bills as All Other, Part B 100 percent, renal bills, and ASC.

FIELD DESCRIPTIONS:

1.	Paid Dates	The first and last paid dates of the period that the report covers.
2.	Run Date	The date on which the system produced this report.
3.	Provider FYE	The month and day that mark the close of the provider's FY.
4.	Provider Number	The number identifying the provider is followed by the provider name as it appears on the provider table.

Columns:

5.	Revenue Code/ Description	The revenue code number is followed by the description as it appears on the revenue code summarization table.
6.	Services for Period	Four service periods are shown based upon dates of service as selected by the user.
7.	Units	The medical units (days, treatments, or services), associated with the revenue code.
8.	Charges	The total charges, as assigned to the revenue code by the PS&R interface program.

Rows:

9.	Accommodations Census	This contains information for the revenue codes flagged as accommodation revenue codes on the revenue code Summarization Table for the provider.
10.	Total Accommodations	The sum of all the units (days) and charges in each service period for the accommodation revenue codes listed.
11.	Discharges	The number of discharges for each period.
12.	Days Full	The number of inpatient Medicare days for which Medicare paid the full Medicare coverage amount.
13.	Days Coinsurance	Total inpatient coinsurance days that were covered under Medicare, as confirmed by you, for each service period.
14.	Days Lifetime Reserve	Number of inpatient days for which Medicare paid the Lifetime Reserve Benefit amount for each service period.

15.	Claims	Number of claims received by the PS&R system for each service period. The claim count is incremented whenever a claim (CMS-1450) is processed with a bill frequency 0, 1, 2, 3, 4, or 7 and is decremented whenever a claim (CMS-1450) is processed with a frequency of 8. All other frequencies have no effect on claim (CMS-1450) counts.
16.	Ancillary Charges	This contains information for the revenue codes flagged ancillary on the revenue code summarization table for this provider.
17.	Total Ancillary	The sum of all units and charges in each service period for ancillary revenue codes listed.
18.	Total Charges	The sum of all charges in each service period for all revenue codes listed.
19.	Hosp Specific	That portion of the DRG payment sum which is based on the hospital specific rate.
20.	Fed Specific	That portion of the DRG payment sum which is based on the federal specific rate.
21.	Transfer Payment	The reimbursement amount for transfer claims as determined by the patient discharge status of "2" (transfer to another short-term general hospital) with any cost outlier payment excluded.
22.	Days Outlier	The sum of day outlier payments made under the PPS. (Obsolete after FY 1997.)
23.	Cost Outlier	The sum of cost outlier payments made under the PPS.
24.	Gross Reimbursement	The sum of net reimbursement from Medicare, Blood and Cash Deductible amounts, and the coinsurance amount.
25.	Cash Deductible	The inpatient hospital deductible payable by the patient.
26.	Blood Deductible	The cash blood deductible payable by the patient.
27.	Coinsurance	The patient coinsurance amount payable by the patient.
28.	Net Reimbursement	The total amount the provider received from Medicare during the period indicated on the report.
29.	Net Primary Payments Made Under MSP	The net amount payable by a higher priority health insurer that is used to reduce Medicare liability. This amount does not include full payments by other payors.
30.	DSH Payments	Additional payments to disproportionate share hospital providers.
31.	Interest Payments	Interest payments made by the intermediaries on claims that exceeded the prompt payment requirements.
32.	ASC Standard	The calculated cost limit for all ASC services on the bill. This

	Overhead (ASC - FEE)	field appears on the ASC report only.
33.	Radiology Prevailing Charge	The calculated cost limit for all Radiology services on the bill. This field appears on the Radiology report only.
34.	ESRD Network Payments	The reduction in hospital outpatient renal dialysis payments for allocation to ESRD networks.
35.	Indirect Medical Education Payment	Additional payments to teaching facilities qualifying for the indirect medical education adjustment.
36.	Total Adjustments	The total charges for any adjustments applied via the provider summary correction process for the period indicated on the report.
37.	Unknown Revenue Code	Whenever this description appears, the indicated revenue code was not found on the revenue code summarization table at the time the summary reports were produced. The revenue code summarization table or the claim (CMS-1450) record should be updated before further processing.

30.3 - DRG Summary Report - (Rev. 10, 08-30-02)

A2-2243C

This report for PPS is a supplement to the provider summary report and is produced when a provider summary report is produced for any given provider. The report is a summary of prospective payment data broken out and summarized by DRG code.

1.	**Paid Dates**	**The first and last dates of the period that the report covers.**
2.	Run Date	The date on which the PS&R system produced this report.
3.	Provider FYE	The month and day that mark the close of the provider's FY.
4.	Provider Number	The number identifying the provider is followed by the provider's name as it appears on the provider table.
5.	Services Rendered	The first through the last dates of service which are included on this report.
6.	DRG	The DRG for which summary data is being reported.
7.	Discharges	The sum of all discharges for the DRG.
8.	Transfer Days Paid	The sum of all covered days for a transfer claim (CMS-1450).
9.	Outlier Days	The sum of covered days for day outlier claims.
10.	Hosp Specific Portion	That portion of the DRG payment sum which is based upon the hospital specific rate.

11.	Fed Specific Portion	That portion of the DRG payment sum which is based on the Federal specific rate.
12.	DRG Portion	The sum of the Federal specific portion and hospital specific portions reported in columns 5 and 6.
13.	Transfer Portion	The sum of the reimbursement amounts for transfer out claims. Any outlier payment is not included. Transfers are those claims with a discharge status "2."
14.	Days Outlier Portion	The sum of payments for the outlier portion of day outlier claims. (Obsolete after FY 1997.)
15.	Cost Outlier Portion	The sum of payments for the outlier portion of cost outlier claims.
16.	Total Payments	The sum of all payments made to the provider including beneficiary deductible and coinsurance.
17.	Deductible	The inpatient hospital deductible payable by the patient.
18.	Coinsurance	The patient coinsurance amount payable by the patient.
19.	Net Payments	The sum of the amounts actually paid by Medicare to the provider by DRG.
20.	Net Primary Payments Made Under MSP	The net amount payable by a higher priority liability. This amount does not include full payments by other payers.
21.	Total Covered Charges	The sum of total Medicare covered charges.

30.2 - Provider Summary Reports - (Rev. 10, 08-30-02)

A2-2243B

Summarizes claim data and other information by revenue code required for cost report settlement and CMS reporting purposes. Time periods included on this report are specified by the user.

All outpatient ASC and clinical lab services reimbursed by HCPCS are summarized separately on the clinical lab report and the ASC report.

FREQUENCY: Upon request.

REPORT TYPES: A report is generated for each type. These report types are based on the first two digits of the Bill Type code on the provider's claim form (CMS-1450). Report claims which cannot be mapped to one of the report types under "UNKNOWN REPORT TYPE." PS&R system report types are:

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120	Inpatient Part B

130	Outpatient - All Other
131	Outpatient Renal
132	Outpatient - Part B 100 Percent
139	Outpatient - Radiology and Fee Schedule
140	Outpatient - Clinical Lab Nonpatient
210	SNF Inpatient Part A
220	SNF Inpatient Part B
230	SNF Outpatient
320	Home Health Part B with a Plan of Treatment
330	Home Health Part A with a Plan of Treatment
340	Home Health Part B without a Plan of Treatment
410	Religious Nonmedical Health Care Hospital - Inpatient Part A
420	Religious Nonmedical Health Care Hospital - Inpatient Part B
430	Religious Nonmedical Health Care Hospital - Outpatient - All Other
431	Religious Nonmedical Health Care hospital - Outpatient - Renal
432	Religious Nonmedical Health Care Hospital - Outpatient - Part B 100 Percent
440	Religious Nonmedical Health Care Hospital - Clinical Lab Non-Patient
510	Religious Nonmedical Health Care Ext Care - Inpatient - Part A
520	Religious Nonmedical Health Care Ext Care - Inpatient - Part B
530	Religious Nonmedical Health Care Ext Care - Outpatient - All Other
650	Intermediate Care - Level I
660	Intermediate Care - Level II
670	Intermediate Care - Level III
710	Clinic - Rural Health
720	Clinic - Free Standing Renal Dialysis
730	Clinic - Free Standing
740	Rehabilitation Facility and CORF
790	Clinic - Other
810	Hospice - Non-Hospital Based
820	Hospice - Hospital Based

830	Ambulatory Surgery Center
840	Free Standing Birth Center
890	Special Facility - Other
999	Unknown Report Type

NOTE: In all cases other than outpatient, the report type ties directly to the type of bill entered on the claim (CMS-1450). For outpatient bills, the distinction is broken out further to identify the bills as All Other, Part B 100 percent, renal bills, and ASC.

Field Descriptions:

1.	Paid Dates	The first and last paid dates of the period that the report covers.
2.	Run Date	The date on which the system produced this report.
3.	Provider FYE	The month and day that mark the close of the provider's FY.
4.	Provider Number	The number identifying the provider is followed by the provider name as it appears on the provider table.

Columns:

5.	Revenue Code/ Description	The revenue code number is followed by the description as it appears on the revenue code summarization table.
6.	Services for Period	Four service periods are shown based upon dates of service as selected by the user.
7.	Units	The medical units (days, treatments, or services), associated with the revenue code.
8.	Charges	The total charges, as assigned to the revenue code by the PS&R interface program.

Rows:

9.	Accommodations Census	This contains information for the revenue codes flagged as accommodation revenue codes on the revenue code Summarization Table for the provider.
10.	Total Accommodations	The sum of all the units (days) and charges in each service period for the accommodation revenue codes listed.
11.	Discharges	The number of discharges for each period.
12.	Days Full	The number of inpatient Medicare days for which Medicare paid the full Medicare coverage amount.
13.	Days Coinsurance	Total inpatient coinsurance days that were covered under Medicare, as confirmed by you, for each service period.
14.	Days Lifetime Reserve	Number of inpatient days for which Medicare paid the Lifetime Reserve Benefit amount for each service period.

15.	Claims	Number of claims received by the PS&R system for each service period. The claim count is incremented whenever a claim (CMS-1450) is processed with a bill frequency 0, 1, 2, 3, 4, or 7 and is decremented whenever a claim (CMS-1450) is processed with a frequency of 8. All other frequencies have no effect on claim (CMS-1450) counts.
16.	Ancillary Charges	This contains information for the revenue codes flagged ancillary on the revenue code summarization table for this provider.
17.	Total Ancillary	The sum of all units and charges in each service period for ancillary revenue codes listed.
18.	Total Charges	The sum of all charges in each service period for all revenue codes listed.
19.	Hosp Specific	That portion of the DRG payment sum which is based on the hospital specific rate.
20.	Fed Specific	That portion of the DRG payment sum which is based on the federal specific rate.
21.	Transfer Payment	The reimbursement amount for transfer claims as determined by the patient discharge status of "2" (transfer to another short-term general hospital) with any cost outlier payment excluded.
22.	Days Outlier	The sum of day outlier payments made under the PPS. (Obsolete after FY 1997.)
23.	Cost Outlier	The sum of cost outlier payments made under the PPS.
24.	Gross Reimbursement	The sum of net reimbursement from Medicare, Blood and Cash Deductible amounts, and the coinsurance amount.
25.	Cash Deductible	The inpatient hospital deductible payable by the patient.
26.	Blood Deductible	The cash blood deductible payable by the patient.
27.	Coinsurance	The patient coinsurance amount payable by the patient.
28.	Net Reimbursement	The total amount the provider received from Medicare during the period indicated on the report.
29.	Net Primary Payments Made Under MSP	The net amount payable by a higher priority health insurer that is used to reduce Medicare liability. This amount does not include full payments by other payors.
30.	DSH Payments	Additional payments to disproportionate share hospital providers.
31.	Interest Payments	Interest payments made by the intermediaries on claims that exceeded the prompt payment requirements.
32.	ASC Standard	The calculated cost limit for all ASC services on the bill. This

	Overhead (ASC - FEE)	field appears on the ASC report only.
33.	Radiology Prevailing Charge	The calculated cost limit for all Radiology services on the bill. This field appears on the Radiology report only.
34.	ESRD Network Payments	The reduction in hospital outpatient renal dialysis payments for allocation to ESRD networks.
35.	Indirect Medical Education Payment	Additional payments to teaching facilities qualifying for the indirect medical education adjustment.
36.	Total Adjustments	The total charges for any adjustments applied via the provider summary correction process for the period indicated on the report.
37.	Unknown Revenue Code	Whenever this description appears, the indicated revenue code was not found on the revenue code summarization table at the time the summary reports were produced. The revenue code summarization table or the claim (CMS-1450) record should be updated before further processing.

30.3 - DRG Summary Report - (Rev. 10, 08-30-02)

A2-2243C

This report for PPS is a supplement to the provider summary report and is produced when a provider summary report is produced for any given provider. The report is a summary of prospective payment data broken out and summarized by DRG code.

1.	Paid Dates	
The first and last dates of the period that the report covers.		
2.	Run Date	The date on which the PS&R system produced this report.
3.	Provider FYE	The month and day that mark the close of the provider's FY.
4.	Provider Number	The number identifying the provider is followed by the provider's

			name as it appears on the provider table.
5.		Services Rendered	The first through the last dates of service which are included on this report.
6.		DRG	The DRG for which summary data is being reported.
7.		Discharges	The sum of all discharges for the DRG.
8.		Transfer Days Paid	The sum of all covered days for a transfer claim (CMS-1450).
9.		Outlier Days	The sum of covered days for day outlier claims.
10.		Hosp Specific Portion	That portion of the DRG payment sum which is based upon the hospital specific rate.
11.		Fed Specific Portion	That portion of the DRG payment sum which is based on the Federal specific rate.
12.		DRG Portion	The sum of the Federal specific portion and hospital specific portions reported in

			columns 5 and 6.
13.		Transfer Portion	The sum of the reimbursement amounts for transfer out claims. Any outlier payment is not included. Transfers are those claims with a discharge status "2."
14.		Days Outlier Portion	The sum of payments for the outlier portion of day outlier claims. (Obsolete after FY 1997.)
15.		Cost Outlier Portion	The sum of payments for the outlier portion of cost outlier claims.
16.		Total Payments	The sum of all payments made to the provider including beneficiary deductible and coinsurance.
17.		Deductible	The inpatient hospital deductible payable by the patient.
18.		Coinsurance	The patient coinsurance amount payable by the patient.
19.		Net Payments	The sum of the amounts

			actually paid by Medicare to the provider by DRG.
20.		Net Primary Payments Made Under MSP	The net amount payable by a higher priority liability. This amount does not include full payments by other payers.
21.		Total Covered Charges	The sum of total Medicare covered charges.

40 - Corrections to Individual Records - (Rev. 10, 08-30-02)

A2-2244

The PS&R system allows corrections of total charges and/or units, days/visits, revenue codes within a provider and changes to covered amounts on the provider summary report. The following data are required to make adjustments.

INDIVIDUAL RECORDS

Item	Description	Enter
1.	Request Date	Today's Date
2.	Submitted By	Your Name
3.	Provider Number	The provider to be adjusted.
4.	Report Type	The report type of the provider to be adjusted.
5.	Paid Date	The remittance date for the claim(s) being adjusted.
6.	Thru Date	The thru date of service for the claim(s) being adjusted.
7.	DRG Code	For prospective payment providers, the DRG code under which the change was made. For other providers leave blank.
8.	Add to Revenue Code	The revenue code to receive the new amounts.
9.	Subtract from Revenue Code	The revenue code from where amounts should be subtracted.

10.	Days (Visits)	Number of days/visits to be adjusted between the revenue codes specified.
11.	Charges	Dollar amounts to be adjusted.

The PS&R system processes adjustments with a frequency code of 7 (cancel) and 8 (reissue). Other types of adjustments, e.g., credits and debits, PRO adjustments, cannot be handled by this system. Prepare an interface program that will convert the adjustments to frequency codes 7 or 8 in order to process PRO debit/credit adjustments and maintain the data in the PS&R system for cost settlement.

50 - The PS&R System Data Elements - (Rev. 10, 08-30-02)

A2-2245

Maintain the following data elements from the CMS-1450, Grouper and Pricer, and pass them to the PS&R system in the input record. Asterisked items are not reported in the UNIBILL record; however, you must have this data.

50.1 - Inpatient Hospital/SNF Data Elements - (Rev. 10, 08-30-02)

A2-2245A

1. Record Identification

2. Action Code

3. Adjustment Code

4. HICN

5. Medical Record No.

6. Type of Bill

7. Medical Provider No.

8. Patient Name

   a. Surname

   b. Initial

9. Admission Date

10. Patient Status

11. Statement Covers

    a. From Date MMDDYY

    b. Thru Date MMDDYY

12. Utilization Days

13. Nonutilization Days

14. Cost Report Days

15. First Year Co Days

16. Second Year Co Days

17. Total LTR Days

18. 2nd Year Ltr Days

19. Value Code

20. Value Amounts

21. Revenue Code

22. Revenue Amounts

23. Total Amount

24. Total Noncovered Amount

25. Medicare Reimbursement

26. PPS Hospitals

    a. DRG Code*

    b. DRG Payment*

    c. Transfer Payment*

    d. Federal Specific Payment*

    e. Hospital Specific Payment*

    f. Cost Outlier Payment*

    g. Transfer Days Paid*

    h. Indirect Medical Education Payment*

    i. Outlier Days (Obsolete after FY 1997)*

* UNIBILL does not require this data.

27. Blood

    a. Furnished

    b. Replaced

    c. Unreplaced

d. Deductible

28. Cash Deductible

29. Medicare Secondary Payment

30. Date Processed

50.2 - Home Health/Hospice Data Elements - (Rev. 10, 08-30-02)

A2-2245B

1. Record Identification
2. Action Code
3. Adjustment Code
4. HICN
5. Medical Record No.
6. Type of Bill
7. Medical Provider No.
8. Patient Name
   a. Surname
   b. Initial
9. Start of Care Date
10. Statement Covers
    a. From Date MMDDYY
    b. Thru Date MMDDYY
11. Revenue Code
12. Revenue Amounts
13. HCPCS Code
14. Value Code

15. Value Amounts

16. Units of Service

17. Total Charges

18. Coinsurance

19. Medicare Secondary Payment

20. Medicare Reimbursement

21 Hospice

a. Routine Home Care

b. Continuous Home Care

c. Inpatient Care

d. General Care

50.3 - Outpatient/CORF/RHC Data Elements - (Rev. 10, 08-30-02)

A2-2245C

1. Record Identification

2. Action Code

3. Adjustment Code

4. HICN

5. Medical Record No.

6. Type of Bill

7. Medical Provider No.

8. Patient Name

a. Surname

b. Initial

9. Statement Covers

a. From Date MMDDYY

b. Thru Date MMDDYY

10. Revenue Code

11. Revenue Amounts

12. HCPCS Code

13. Total Charges

14. Total Noncovered Charges

15. Coinsurance

16. Deductible

17. Medicare Reimbursement

18. Value Codes

19. Value Amount

20. Medicare Secondary Payment

21. Date Processed
